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MEMORANDUM

TO: Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations

Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD 
Mike Moseley 

SUBJECT: Implementation Update #38: DHHS Informal Hearings; Authorization Appeals, CAP-MR/DD Continuing Need Reviews, CAP-MR/DD Waiver Update, Information Needed by Value Options, Removal from Payment Withhold, Plans of Correction Resulting from Community Support Service Record Reviews, Community Support Service Definition Update, Providers Change of Location Clarification, Revised Routing of NEA Withdrawal Letters, National Accreditation Alert and State Contract Edit Window

Department of Health and Human Services (DHHS) Requests for Informal Hearings

While a DHHS informal hearing is not a legal proceeding, a request for an informal appeal must be completed and submitted correctly so the recipient and/or his/her legal representative can participate fully in the hearing proceeding. Therefore, it is imperative that meticulous attention be given to completing the informal appeal request form and to preparing for the appeal. Please review and implement the guidelines specified below.

1. For purposes of this section a "legal representative" means a parent, other relative or legal guardian. The word "representative" means a person or persons chosen by the recipient or recipient's legal representative to speak for the recipient at the hearing.
2. **ONLY the recipient and/or his/her legal representative** may request an informal appeal. If a recipient has been adjudicated incompetent, the informal appeal request form must be signed by the legal representative. Preferably, the form should be signed by the next of kin (mother, father, sibling, etc.) if the recipient has not been adjudicated incompetent but would be unable to understand or participate in the hearing process. The initial/concurrent blocks are for internal use and do not need to be initialed.

3. A Medicaid recipient can be represented by a non-attorney representative in either an informal or formal appeal. 42 C.F.R. 431.206(b) states that a representative may be "legal counsel, relative, friend, or other spokesman". This means that a provider may represent a recipient **IF** the provider has verbal or written authorization from the recipient to do so. In the case of an incompetent recipient, such authorization must be given by the legal representative or person with power of attorney. Recipients and/or providers are encouraged to include written documentation supporting this along with the completed informal appeal request form.
4. When the DHHS Hearing Office receives a request for an informal appeal and using the information provided on the informal appeal request form, the recipient and/or his/her legal representative are notified of the date and time of the hearing by certified mail. Therefore, when requesting an informal appeal, it is important that the **recipient section** contain the **recipient's and/or his/her legal representative's** signature, current address and telephone number.

If the recipient and/or his/her legal representative invite the provider to participate in or represent them in the hearing **and list the provider** in the **representative section** at the bottom of the appeal form, the provider will be sent a copy of the Notice of Hearing via first class mail (United States Postal Service). A form completed with only the provider's contact information usually results in hearing delays because the recipient's intent regarding his/her participation in the informal hearing must be determined
5. When the provider receives notification of the date and time of the hearing, consider contacting the recipient and/or his/her legal representative and explain that a certified letter from the North Carolina Department of Health and Human Services has been sent to them regarding the hearing. Please share with them that the notice will only be delivered if they sign the notification card and return it to the post office. Also, please advise them of the date and time of the hearing and encourage them to confirm their participation in the hearing and/or to provide new telephone numbers where they can be reached on the day of the hearing. Lastly, please advise the recipient and/or his/her legal representative that the North Carolina Administrative Code, Title 10A, Subchapter 22 H, section .0105(b) allows the hearing to be conducted without their participation if the applicant fails to appear at the scheduled time without good cause. The code defines good cause as "circumstances beyond the control of the applicant/recipient or his/her representative".
6. The provider should consider contacting the recipient and/or his/her legal representative a few days prior to the hearing and remind them of the date and time of the hearing.

Service Authorization Appeals

We need to clarify the December 3 update concerning restrictions on appeals filed by providers on behalf of clients. It IS permissible for providers to file a formal or informal appeal on behalf of a client and to sign that appeal request IF the provider has verbal or written authorization from the client to do so. In the case of an incompetent client, such authorization must be given by the legal representative or person with power of attorney. No appeal filed by a provider will be dismissed if it is verified that such authorization existed. The family/legal representative **MUST** be aware of what is being appealed and why. Under no circumstances may an appeal be based upon financial needs of the provider rather than the medical needs of the client. In addition, providers shall not coerce families or the legal representative in filing an appeal.

CAP-MR/DD Continuing Need Reviews

DMA and DMH have been evaluating the current process regarding the review of CAP-MR/DD Continued Need Reviews (CNRs). Due process requires that the particular service which is being denied, terminated or reduced be identified in the written notice. It is not sufficient to say that the plan of care has been denied. We are in the process of changing Value Options (VO) notices to correct this problem. Services requested in the plan that are not specifically denied, terminated, or reduced are approved. If you have specific questions about the service reduction, termination or denial, please contact VO at 888-510-1150 and ask for Provider Relations.

If a service is already being provided under the old CAP-MR/DD plan and upon the submission of the new CNR the request is made for the continuation of the service and as a result of the VO review, a VO decision is made not to continue authorization or to reduce the hours of that service, this is considered a reduction or termination of services and due process rights must be provided. This means that if an appeal of that decision is requested, maintenance of services applies. The provider should continue to provide the service at the prior level pending the outcome of the appeal.

CAP-MR/DD Waiver Update

Session law 2007-323, House Bill 1473, Section 10.49 (dd) requires the DHHS to develop and apply to the Centers for Medicare and Medicaid Services (CMS) for additional home and community based waivers for individuals with developmental disabilities. The new waivers are intended to create a tiered system of services and supports. We plan to

submit the tiered waivers to CMS by April 1, 2008. The current CAP-MR/DD waiver will expire August 31, 2008 and it is our intention to have the new waivers begin effective September 1, 2008. Internally the Divisions of MH/DD/SAS and Medical Assistance have created a work plan to address the development of the waivers. A general stakeholder meeting occurred in December as a first step to provide information regarding waiver development. A Communications Plan will be incorporated into the waiver development work plan and will provide a variety of opportunities for stakeholder participation. Stakeholders will be invited to participate on external workgroups to provide input into the development of the specific components (Appendices) of the waivers. Specific components/appendices of the waivers will be posted on the DMH/DD/SAS website for public review and input. Progress with the development of the waivers will be reported in each monthly Implementation Update. Please visit the DMH/DD/SAS website often to review current progress with the development of the waivers.

Information Needed by Value Options

It is the responsibility of the provider or case manager to include current clinical information with each request for services. If VO needs further information to make a decision, VO will request that information from the provider within 15 days of the request. It is critical that providers promptly reply to these requests for additional information or the request may be denied.

Removal from Payment Withhold

Providers were notified by the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services of serious irregularities in billing Community Support Services to the Medicaid program, potentially resulting in overpayments and/or invalid payments. As a result, certain providers were placed on 10% withhold of all Medicaid payments until such time as billing practices comply with minimum required standards defined in policy.

A post payment review of provider medical records by Local Management Entities (LMEs) has confirmed inappropriate payments for medically unnecessary Community Support Services. Affected providers are receiving notification of refunds due back to the Medicaid program.

In order to be taken off the current withhold of payments, providers must comply with all of the following requirements:

- Full refund to Medicaid of identified overpayments as a result of post payment review,
- Produce an LME-approved Plan of Correction,
- Perform a self-audit of Community Support Services, in accordance with DMA Program Integrity self audit protocol, and repay the Medicaid program for any Community Support Services that are non-compliant with Medicaid requirements, and
- Produce proof of attendance at training on Medicaid billing and documentation requirements for Community Support Services.

Plans of Correction Resulting from Community Support Service Record Reviews

With the exception of two extensions, LMEs have completed the Service Record Reviews which were a result of the Post-Payment Clinical Reviews of community support providers. Many of these providers were the same companies who were included in the late winter and early spring 2007 Community Support Medicaid audits. The Service Record reviews covered a similar timeframe of paid claims dates as the audits. The audits had required Plans of Correction (POC) assigned based on areas found out of compliance. The LMEs approved the POCs and followed-up to ensure implementation of the POCs.

When a provider has the same areas found out of compliance in their Service Record Review as was found in the Medicaid audits and it warrants a plan of correction, new POCs shall not be assigned. The LME should note the deficient areas and document the already approved and implemented POC(s) from the audit cycle(s) as evidence of the process being completed. If any additional areas are found out of compliance and warrant a POC, the original POC process must be followed.

Community Support Service Definition Update

As announced at the December 18th DMA/DMH video conference, the revised Community Support definitions for children/adolescents and adults were reposted for 15 days to allow for review of changes made as a result of the initial 45 day posting. Comments on the reposted definition will be accepted through January 9, 2008. DMA and DMH/DD/SAS will review comments received and post the final definitions by the end of January. Implementation of the new definitions is targeted for March 1, 2008.

Providers Change of Location Clarification

When a provider who is endorsed and enrolled to provide services at a specific site moves to an alternate location, the provider must notify via a change of address form the endorsing LME and DMA of the address change. It is important to ensure that the provider number on the change of address form is an exact match to the provider number on the original NEA form. If the site move involves a service and a different LME catchment area, it should be considered a new site subject to a new endorsement and enrollment. However, as long as there is no change in service provision, the current endorsement/enrollment remains active.

Revised Guidance for Routing of Notification of Endorsement Action (NEA) Submissions for Withdrawal of Endorsement

The most recent Endorsement Policy: Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services, Date: December 3, 2007, contains the following guidance on page 8 of 15:

The provider will be notified of the intent to withdraw endorsement via the standard "Notification of Endorsement Action" letter. The basis for the withdrawal of endorsement that is noted on the Notification of Endorsement Action letter shall be consistent with the reasons noted in this policy. The notice/letter will be signed by the Endorsing Agency CEO, submitted to DMA and copied to the DMH/DD/SAS (endorsements.accountability@ncmail.net). If it is a licensable service, the DMH/DD/SAS will copy the letter to the Division of Health Service Regulation.

In order to assure that DMA only receives notification of withdrawal of endorsement only when either the time for registering an appeal of the decision to withdraw the endorsement has passed, or when their first level appeal to DMH has occurred and DMH upholds the decision of the LME, the NEA letter will be sent to DMH/DD/SAS Accountability Team (endorsements.accountability@ncmail.net), and the Accountability Team will forward the withdrawal to DMA Provider Enrollment, only when the time for appeal, or the first level appeal process, has been completed. Therefore, the policy shall be revised to read:

The provider will be notified of the intent to withdraw endorsement via the standard "Notification of Endorsement Action" letter. The basis for the withdrawal of endorsement that is noted on the Notification of Endorsement Action letter shall be consistent with the reasons noted in this policy. The notice/letter will be signed by the Endorsing Agency CEO, and submitted to the DMH/DD/SAS (endorsements.accountability@ncmail.net). If it is a licensable service, the DMH/DD/SAS will copy the letter to the Division of Health Service Regulation. The DMH/DD/SAS will forward the Notification of Endorsement Action letter to DMA at such time as the time for appeal of the action has passed, or at such time as the first level appeal to DMH has been completed.

Please ensure that the NEA letter submitted to DMH/DD/SAS is signed by the Endorsing Agency CEO. Unsigned letters will not be accepted by DMA.

This guidance shall be in effect upon publication of this Implementation Bulletin, and the on-line Notification of Endorsement template will be revised to comply with this policy revision.

National Accreditation Alert

For nineteen (19) services which went into effect in March, 2006, there is in the service definition a requirement that "within three years of enrollment as a provider, the organization must have achieved national accreditation." As the three-year window approaches, it is important for providers, LMEs and consumers and families to be appropriately watchful to ensure individuals who receive MH/DD/SA services are served by agencies who continue to be fully qualified to provide those services.

A couple of frequently asked questions circulate concerning this requirement. They include:

Question: Does the clock for the three years begin with conditional endorsement, full endorsement, or enrollment?

Answer: As stated in the service definition, the "clock" begins with enrollment. Many providers were conditionally endorsed prior to March 2006, and who will continue to provide services have been or are being fully endorsed now, but enrollment for most of these providers began March 2006. If for some reason, enrollment was terminated and then subsequently reinstated, the original enrollment date is the operational date for the three-year clock for accreditation.

Question: Is it the service or the agency/organization which is accredited?

Answer: In practical terms, it is both, but the service definition specifies the "organization." The way each accreditation agency works is a little different; but in each case, when the accrediting agency takes a provider agency through the accreditation process, that accrediting agency will be assuring that the provider agency is staffed and structured to provide the service as well.

Two accrediting agencies, The Council on Accreditation (COA) and The Commission on Accreditation and Rehabilitation Facilities (CARF), will undertake to apply their service-specific standards to the individual services which the applying agency provides. Since those standards are not exact matches for our North Carolina service definitions, we have worked with these two agencies, CARF and COA, to establish crosswalks of the accrediting standards with our service definitions. Those crosswalks were reviewed by the DMH/DD/SAS Clinical Oversight Team and Executive Leadership Team, and are maintained and revised as necessary by the Accountability Team Policy Unit.

The other two accrediting agencies – The Joint Commission (JCAHO) and The Council on Quality and Leadership (CQL) - have slightly different business practices, but each in its way assures that the provider agency has the appropriate infrastructure and programmatic capability to fully provide the service for which they are enrolled.

We are currently gathering information from the accreditation agencies in several areas: We are receiving numbers and names of agencies with whom the accrediting bodies have corresponded, and with whom the accrediting bodies have contracted to undertake accreditation. This will give us an idea of how many providers have begun the process in earnest, and what their progress is. We are also receiving information concerning average length of time required to complete accreditation, and any backlog or waiting periods in effect due to the volume of applications. We are also updating our information on the number of months of operating records the agencies require for their review prior to their onsite visit(s). These dates and times will allow us to project points beyond which there may be the danger of not completing accreditation within the three year timelines required, and those projections will allow us to identify procedures for orderly transition of individuals receiving services in the case where not meeting the accreditation timeline triggers a termination of enrollment. More specific guidance addressing these issues will be provided in the February Implementation Update.

Should you have questions about the national accreditation requirement and its implementation, please feel free to contact Jim Jarrard, (jim.jarrard@ncmail.net) at (919) 881-2446.

State Contract and Memorandum of Agreement (MOA) Edit Window

The Division of MH/DD/SAS will be accepting edit comments for the state funded contract as well as the MOA between LME's and direct enrolled providers between January 1 and February 29, 2008. A copy of the state funded contract can be accessed at <http://www.ncdhhs.gov/mhddsas/announce/commbulletins/commbulletin054/lme-statefundprovide6-13-07contract.doc> and a copy of the MOA can be accessed at <http://www.ncdhhs.gov/mhddsas/announce/commbulletins/combullerin044/commbulletin44moa5-15-06.pdf>; edits should be submitted to Marie Kelley at marie.kelley@ncmail.net.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Dempsey Benton
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